Procedures
Early Application/State Hospital
March 11, 2005

1. BES will accept Medicaid applications prior to an applicants release from the State Hospital – 30 days before discharge if the person is already "officially disabled" (they received SSI or SSA as a disabled person, or had been determined disabled the Medicaid Medical Review Board at the time they entered the State Hospital)

- 60 days before discharge if the person is not already "officially disabled"
- 30 days before discharge if the person is 65 years of age or older and not already getting Medicaid
- 30 days before discharge if the person is younger than 19 and not already getting Medicaid.

2. All applications accepted before release must include a complete cover sheet (attached). Also, the top of the application must be marked with "Early Release Case – attn: Kym Ney".

3. The application must be signed by the applicant.

4. All applications must include a signed 114R Authorization to Disclose Health Information (attached).

5. All applications must include a signed 114PI Authorization to allow Medicaid to share confidential personal information with the State Hospital (attached).

6. For applications where it is anticipated that we will need to determine disability, a completed 354 should also be included with the application. Also, if any available medical records can be included with the application, it will speed up the disability determination process.

7. Applications submitted as part of this process will only be for individuals who have a high likelihood of qualifying for Medicaid (anyone can apply for Medicaid, but for this program we require applications to be screened prior to submittal).

8. Web sites that may prove helpful are

- down load forms http://health.utah.gov/eol/
- Medicaid policy http://erws01spr.erep.state.ut.us/infosourcemedicaid/

9. Questions, concerns, feedback can be forwarded to Jacky Stokes (801-538-6418), Rex Dunn (435-896-1295), Kym Ney (801-344-4632), or Linda Gustin (802-371-1014).

TO: BES/Early Application for State Hospital 3/28/05
ATTN – Kim Ney SH Cover Sheet
Phone # 801-344-4632
Fax # 801-344-4607

FROM: _____ (contact person – someone at the State Hospital)
_____ (phone #)

DATE: _____

Attached is a completed Medicaid application, along with a signed 114R (Authorization to Disclose Health Information) and a 114 SH (Authorization to share Confidential Information)_____
For _____, SSN#_____ who is currently a resident at Utah State Hospital.

The above name person is scheduled to be released from this facility on _____.

This person has been in this facility since _____.

The terms of this person's release from this facility are:

_____ conditional leave – (i.e., when the resident is released from the institution on the condition that the residents receive outpatient treatment)

_____ Convalescent leave (i.e., resident is sent home from the institution for a trial visit.

_____ To get Medical care

_____ Unconditional Release

_____ Other. Please explain_____
_____.

Once released, this person plans to live:

_____ They are returning home
_____ They do not know where they will live
_____ Other. Please explain_____
_____.

This person was____ was not ____ on Medicaid or receiving Social Security Benefits in the year before they entered the institution?_____.

Where?_____
Date benefits ended_____

The medical needs this person has, that will be a particular concern during the 30 days following his/her release, are_____
_____.

HCFBES/114SH
3/05

AUTHORIZATION TO DISCLOSE CONFIDENTIAL PERSONAL INFORMATION

(For Medicaid/CHIP Agency*, To Disclose Information)

_____ _____ _____/_____/_____

Client Name **Social Security #** **Date of Birth**

I _____ hereby authorize

(Client or Personal Representative)

Medicaid to disclose confidential personal information from the records of the above named person to:

_____

(Person or Organization Receiving the Information)

_____.

The specific confidential information authorized for disclosure is: **____status of my application for Medicaid - information about what I need to do to in order to complete my application for Medicaid__**_____.

The purpose of the disclosure is: **_____I am currently a resident of State Hospital. While I am here, I need help with my application for Medicaid._____**_____.

I understand that this authorization will expire on the following date, event, or condition: **___when I leave the State Hospital**_____.

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose. I also understand that I may revoke this authorization at any time, by sending written notification to the Medicaid Agency which handles my eligibility case.

I understand that I may refuse to sign this Authorization. I also understand that I cannot be denied eligibility for benefits if I refuse to sign this Authorization.

I understand that I may request a copy of this signed authorization.

_____/_____

Signature of Client or Authorized Representative Date

If signed by an Authorized Representative, a description of authority to serve: _____

_____.

A PHOTOSTATIC OR FAX COPY OF THIS AUTHORIZATION IS CONSIDERED VALID

HCFBES/114R
3/04

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

(For Disclosure To Health Care Financing/Children's Health Insurance Program, and the Department of Workforce Services)

_____ _____ _____/_____/_____

Client Name **Social Security #** **Date of Birth**

I _____ hereby authorize

(Client or Personal Representative)

____**Persons or organizations that hold my personal Health Information**_____ to disclose specific

health information from the records of the above named client to the Utah Department of Health, Division of Health Care Financing or the Department of Workforce Services.

The specific health information authorized for disclosure is: _____

_____.

The purpose of the disclosure is: _____

_____.

I understand that this authorization will expire on the following date, event, or condition: _____

_____.

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose. I also understand that I may revoke this authorization at any time, by sending written notification to Privacy Officer indicated in the Notice of Privacy Practices already provided to the client (a duplicate Notice of Privacy Practices can be provided upon request when filling out this authorization). I understand that a revocation is not effective to the extent that the Division of Health Care Financing or the Department of Workforce Services has relied on the disclosed health information.

I understand that I may refuse to sign this authorization. I also understand that the Division of Health Care Financing or the Department of Workforce Services cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign this authorization.

I understand that, once information is disclosed pursuant to this authorization, it is possible that it will no longer be protected by medical privacy laws and could be redisclosed by the person or agency that receives it.

By signing, I acknowledge I have been provided a copy of this signed authorization.

_____/_____

Signature of Client or Authorized Representative Date

If signed by an Authorized Representative, a description of authority to serve: _____

MEDICAID DISABILITY APPLICATION

SHADED AREA TO BE COMPLETED BY WORKER			
Worker's Name	**Worker's Address**	**Worker's Phone #**	**Client ID#** **PACMIS CASE#**

The following sections to be completed by applicant or representative
Return completed form to the Worker/Address indicated above

1. Name _____ Social Security No.
   Birth date _____ Phone Number
   Address _____ City _____ Zip

2. What is your Disabling Condition? (Describe the illness or injury that keeps you from working).

3. When did your Condition Make you stop working? Month _____ Year

4. Work History- List the jobs you have had in the past 15 years. Use a continuation page if necessary.

JOB TITLE (List last job, next to last job, and so on)	**NAME OR TYPE OF COMPANY**	**DATES WORKED (Month and Year)**		**DAYS PER WEEK**
		FROM	**TO**	

5. Education - What is the highest school grade you completed and when?
   List any special training you have had (trade schools, technical courses, etc.).

6. Indicate the **Doctor who has the latest medical records** about your disabling condition.

NAME	ADDRESS	PHONE NUMBER
HOW OFTEN DO YOU SEE THIS DOCTOR	DATE YOU **FIRST SAW** THIS DOCTOR	DATE YOU **LAST SAW** THIS DOCTOR
REASON FOR VISITS. (Show illness or injury for which you had an examination or treatment)		

7. List any **Other Doctors** you have seen in the last 12 months.

NAME	ADDRESS	PHONE NUMBER
HOW OFTEN DO YOU SEE THIS DOCTOR	DATE YOU **FIRST SAW** THIS DOCTOR	DATE YOU **LAST SAW** THIS DOCTOR
REASON FOR VISITS. (Show illness or injury for which you had an examination or treatment)		

NAME	ADDRESS	PHONE NUMBER
HOW OFTEN DO YOU SEE THIS DOCTOR	DATE YOU **FIRST SAW** THIS DOCTOR	DATE YOU **LAST SAW** THIS DOCTOR
REASON FOR VISITS. (Show illness or injury for which you had an examination or treatment)		

8. List the **Hospitals** where you have been treated in the last 12 months

NAME OF HOSPITAL OR CLINIC		ADDRESS
DATES OF **ADMISSIONS**	DATES OF **DISCHARGES**	DATES OF **OUTPATIENT** VISITS
REASONS FOR HOSPITALIZATION OR CLINIC VISITS. (Show illness or injury for which you had an examination or treatment)		

NAME OF HOSPITAL OR CLINIC		ADDRESS
DATES OF **ADMISSIONS**	DATES OF **DISCHARGES**	DATES OF **OUTPATIENT** VISITS
REASONS FOR HOSPITALIZATION OR CLINIC VISITS. (Show illness or injury for which you had an examination or treatment)		

9. **Other agencies/programs** you are involved in (Voc Rehab, Mental Health, VA, SSI, etc.)

NAME OF AGENCY	**ADDRESS**	**DATE OF VISITS**

10. Have you had any of the following **tests or procedures** in the last year?

NAME OF TEST	CHECK BOX	WHEN	WHERE
Electrocardiogram and/or Exercise test	☐ Yes ☐ No		
X-Rays (indicate areas - chest, knee, etc.)	☐ Yes ☐ No		
Breathing Tests	☐ Yes ☐ No		
Blood Tests	☐ Yes ☐ No		
Surgery/biopsy(Describe)	☐ Yes ☐ No		
Other (Specify)	☐ Yes ☐ No		

If more space is needed to list other doctors, hospitals, agencies, etc., use section 12

INFORMATION ABOUT YOUR ACTIVITIES

11. Describe your **current activities** in the following areas. How much/often do you perform them?

Household maintenance (For example: cooking, cleaning, shopping, paying bills and performing odd jobs around the house as well as any other similar activities):
Social contacts: (For example: visits with friends, relatives, neighbors, attending church, parties, etc)
Recreational activities and hobbies (For example: hunting, fishing, bowling, hiking, playing musical instruments, eating out, playing cards or board games, going to movies, reading or watching television, etc.)
Other (For example: driving cars, riding with others, riding the bus, riding bicycles, walking, etc.)

12. Use this section for additional space to answer any previous questions.

Completed by: _____ **Date:**

Signature

If completed by other than applicant, indicate relationship to applicant: